November 29, 2000

Professor Stuart Altman
Sol C. Chaikin
Professor of National Health Policy
Brandeis University
415 South Street
Waltham, MA 02454

The Honorable Herbert Wilkins
Executive Office of Health & Human Services
One Ashburton Place
Room 1109
Boston, MA 02108

Dear Professor Altman and Justice Wilkins,

At the last meeting of the Health Care Task Force, you reported that the Finance Working Group would be developing an interim report with recommendations before the end of the year. We would like to offer our perspective on the Task Force discussion so far, and the actions we believe the state can and should take to improve health care in the Commonwealth.

We believe that a broad consensus has developed on three fundamental points:

1. Massachusetts hospitals, as a whole, are in the worst financial condition of any in the country;

2. The principal cause of this financial distress is that all three major payers – the federal government, state government and the private sector – are paying hospitals less than what it costs to care for patients;

3. State government should take immediate action to stabilize the commonwealth's fragile health care delivery system.

We further believe that measures to stabilize the system must focus on policies that reduce –rather than perpetuate – the underpayment causing the financial distress. This means urging Medicare, Medicaid, and private insurers to pay responsibly for the care of their subscribers or recipients.

Unfortunately, the prospects for immediate improvement in Medicare and private payments are mixed at best:

On ***Medicare***, we continue to work closely with our congressional delegation and colleagues across the country to restore a portion of the remaining BBA cuts before Congress adjourns. The prospect for additional relief – once promising – now rests with a lame duck Congress meeting in the aftermath of a contentious presidential election. The outlook for this partial relief is not encouraging and relief, if passed, would restore about 10% of the original BBA cuts.

On the ***private*** side, it is unclear whether recent premium increases will result in improved payments to caregivers. Recent high profile negotiations between HMOs and hospitals may signal a shift in the marketplace, but many hospitals still do not have sufficient market presence to achieve more favorable payments from insurers. We believe private employers and state officials must make clear to the state's HMOs that underpaying caregivers will deepen the hospital financial crisis and that the financial recovery of both health plans and hospitals depend on equitable sharing of the premium dollar.

Since ***state government*** has limited influence over Medicare and private insurers, it must fulfill its own responsibilities in ways that reduce, not exacerbate the financing crisis. The two state programs with the greatest financial impact on hospitals are Medicaid and the uncompensated care pool.

Estimates by the Finance Working Group and others place aggregate Medicaid payments at somewhere around 80% of the cost of treating Medicaid hospital patients. Increasing rates to close this gap (half of which is reimbursed by the federal government) would immediately help hospitals, especially those who serve a large population of low-income patients.

Similarly, the state could help ***all*** hospitals if federal matching funds (or other funds) were used to reduce the uncompensated care pool assessments that hospitals pay *above and beyond* the free care they already provide to their communities. This approach – more typical of how uncompensated care pools are financed in other states – would allow local communities to retain millions of dollars to support local programs and needs. At a minimum, we believe we should immediately move to a model that has the pool funded equally by hospitals, health plans, and government.

Since we expect the state task force report to focus on the *immediate* options for the state, it is critical that state attention and resources be focused first on Medicaid and the uncompensated care pool. The adjustments outlined above would not only provide immediate and significant relief, they represent sound public policy.

Within this context, proposals to segregate special funds for "distressed hospitals" can be more clearly evaluated. By putting state resources first into providing Medicaid and pool relief, we accomplish <u>five</u> goals:

1. We address two significant <u>causes</u> of financial losses and reduce the number of hospitals which may be considered "distressed" in the first place.
    - Fewer "distressed hospitals" reduces the funding requirements for a special fund

2. We <u>leverage federal dollars</u> since both Medicaid and the pool are sources of federal matching funds
    - A "special" fund would have no such opportunity

3. We establish a responsible and <u>continuing</u> policy framework that can contribute to future stability
    - By definition, the special fund concept is a one-time mechanism, not addressing the underlying systemic causes of financial distress

4. We provide <u>preventive</u> help to hospitals who may be on the edge today but could become – without help – "distressed" tomorrow
    - Without systemic assistance, the special fund could become a "revolving door" of needy institutions

5. We focus on sound policy principles such as fair payment and shared responsibility (i.e. of the hospitals to provide care to all and of the state to help support those who serve a disproportionate share of the poor)
    - A myriad of complicated questions about definitions and qualifications for "distressed" relief are avoided.

Despite our desire to minimize the need for a special fund, we do believe the Task Force should consider how the state can and should respond when the imminent closure of an institution could precipitate a public health crisis in a given community. Perhaps a review of past Massachusetts' attempts to provide regulatory and legislative assistance to local health facilities could provide further insight to the Task Force on the strengths and/or weaknesses of various approaches.

We need immediate action on reform because our patients and communities depend on a strong and stable health care system. The signs of crisis are everywhere: emergency department diversions, increased wait times for emergency and other specialized services, labor shortages, and a growing number of providers struggling just to survive. At the same time, hospitals are facing enormous cost pressures from increasing pharmaceutical prices, advancing technologies, a growing labor shortage, and the aging of our population. Our collective efforts should be focused on protecting access to the high quality of care Massachusetts residents have come to expect.

The hospital community appreciates the time and energy you have both given to the work of the task force, and we stand ready to work with you as you develop your interim report and recommendations.

Sincerely,

Ronald M. Hollander
President and CEO

Copy: Governor A. Paul Cellucci
Secretary Stephen Crosby
Secretary William O'Leary
Commissioner Wendy Warring
Commissioner Louis Freedman
MHA Board of Trustees
Hospital Representatives serving on State Task Force on Health Care Reform